INSTRUCTIONS FOR FILING - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **www.state.hi.us/dcca/pvl**

APPLICATION

Complete the attached application form. Type or print legibly in dark ink. Applicants are subject to requirements in effect at the time of filing.

- **Failure to provide all the requested information will delay the processing of your application.**

FEES

ATTACH check made payable to: *COMMERCE & CONSUMER AFFAIRS* as follows:

Application for licensure without examination:

If licensed from July 1 of an even-numbered year to June 30 of an odd-numbered year, pay $400
(Application fee-$50 + License fee-$200 + $40 for second year of two-year license period + $110 Compliance Resolution Fund)*

If licensed from July 1 of an odd-numbered year to June 30 of an even-numbered year, pay $305**
(Application fee-$50 + License fee-$200 + $55 Compliance Resolution Fund)*

* *Application fee not refundable.*
** *Subject to renewal June 30, even-numbered year.*

Note: *One of the numerous legal requirements that you must meet in order for your new license to issue is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a $15.00 service fee will be charged for checks which are returned by the bank.*

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

REQUIREMENTS FOR LICENSURE:

Pursuant to Section 460-6 of the Hawaii Revised Statutes, to be eligible for licensure, an applicant must meet the following requirements:

1. Be a graduate of a school or college of osteopathy which is approved by the American Osteopathic Association;
2 Served an internship of at least one year in a hospital approved by the American Osteopathic Association and the American College of Osteopathic Suregons, or in a hospital approved by the American Medical Association; and
3. Passed the National Board of Osteopathic Medical Examiners examination (NBOME), the Federation Licensing Examination (FLEX), the United States Medical Licensing Examination (USMLE), or a combination of parts of the FLEX and the USMLE as approved by the Board.

DOCUMENTS REQUIRED

1) ATTACH photocopy of OSTEOPATHIC MEDICAL SCHOOL diploma,
2) ATTACH photocopy of RESIDENCY certificate,
3) ATTACH photocopy of NBOME, or FLEX, or USMLE examination scores.
4) Attach NPDB verification.
5) Have the state agencies where any license was held complete the attached *"Verification of License"* forms. Duplicate as needed. Applicant is required to send the attached *"Verification of License"* forms to ALL states where a license was ever held.
6) Certificate of Competency must be completed and submitted by two Osteopathic physicians.

(CONTINUED ON BACK)

NATIONAL PRACTITIONER DATA BANK REPORT

Physicians who are licensed in a state or U.S. territory are directed to call the Data Bank at 1-800-767-6732 to request a form for self-query. After completing the form, return it directly to the Data Bank. They will send you the report. You are then to forward the report titled "Search Result - NPDB" (not HIPDB).

Physicians who are not licensed (or have never been licensed) by another state or U.S. territory are directed to complete the attached Affidavit attesting to this fact, and submit it with the application.

AOA PHYSICIAN PROFILE

Complete the AOA Physician Profile request, attach a check in the amount of $40 and send to address noted on form.

(AOA charges a fee of $40 for non-members. No fee for AOA members.)

BOARD'S ADDRESS

Mail all required items to:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801

OR

Deliver to office location at:

1010 Richards St., 1st Floor
Honolulu, HI 96813
Phone No. (808) 586-3000

LAWS & RULES

To obtain copies of the pertinent laws and rules, send a check (made payable to Commerce & Consumer Affairs) in the appropriate amount and a request to: Cashier, Commerce & Consumer Affairs, P.O. Box 541, Honolulu, HI 96809. In your request, please specify that you would like to obtain copies of:

1. Chapter 460, Hawaii Revised Statutes - 50¢
2. Chapter 93, Hawaii Administrative Rules - 50¢
3. Chapter 436B, Hawaii Revised Statutes – The Professional & Vocational Licensing Law may be purchased separately for 75¢.

- The rules are posted on our website at: www.state.hi.us/dcca/pvl, then click the specific board/program. The laws will be posted during the fall of 2001.

APPLICANTS WITH SPECIAL NEEDS

If you are requesting special testing arrangements due to a disability, call (808) 586-2711 immediately to obtain a Disability Certification Form which must be completed by an approved professional, and submitted preferably prior to your exam application, but no later than the exam filing deadline. Determination of qualification for special testing arrangements will then be made and if so, the type of special testing arrangements to be provided.

No action will be taken to provide special testing arrangements until your exam application has been approved.

ABANDONMENT OF APPLICATION

You must submit all required documents and information within two years from the last date documents or information were requested or it will be considered abandoned and the Board may destroy it.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

APPLICATION FOR LICENSE - OSTEOPATHIC PHYSICIAN & SURGEON

Read the attached instructions before completing this form.

Effective Date	License No. DOS -

LEGAL NAME (First-Middle)	(LAST)
Other names used (previous surnames, maiden name, etc.)	
Residence Address (include apt. no., city, state and zip code)	
Mailing Address (**ONLY** if different from above)	
Social Security No.	Phone No. (days)
Date NPDB Requested	Date AOA Profile Requested

FOR OFFICE USE ONLY

EDUCATION

Name of College University/Institute	Location (City/State)	Major Course of Study	Degree Earned	Dates (mo/yr) From	Dates (mo/yr) To
Undergraduate					
Osteopathic					
Internship		AOA or AMA approved? Yes No	No. of beds		

EXPERIENCE

Name of Institution or Employer	Location (City/State)	Specialty		Dates (mo/yr) From	Dates (mo/yr) To
Residency					
Residency					
Practice					
Practice					

Specialty College:

[ ] Candidate [ ] Certified
[ ] Diplomate [ ] Fellow

ALL OTHER STATE LICENSES

Name of State	Date Issued	License Number	Method of Licensure	Date Verification Sent to Other State
			NBOE ST. EXAM FLEX USMLE RECIPROCITY	
			NBOE ST. EXAM FLEX USMLE RECIPROCITY	
			NBOE ST. EXAM FLEX USMLE RECIPROCITY	

(CONTINUED ON BACK)

App..... 464 50
Lic ..... 466 ..... $200
CRF..... C13 ..... $ 55/110

1/2 Renewal ..... 460 ..... $40
Service Fee ..... BCF $15

Name of Applicant: Date:

Circle or underline your answers

1. Are you at least 18 years old? ..... YES NO

2. Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? ..... YES NO

3. Has any license ever been suspended, revoked or otherwise subject to disciplinary action? ..... YES NO

4. Are there any disciplinary actions pending against you? ..... YES NO

5. During the past 20 years have you ever been convicted of a crime in which a jail sentence was imposed and where there has not been any order annulling or expunging the sentence? ..... YES NO
EXPLAIN A "YES" RESPONSE BELOW.

6. Have you ever been treated or are you being treated for alcoholism or drug addiction? ..... YES NO

EXPLANATION

AFFIDAVIT OF APPLICANT:

I, hereby, certify that the answers and statements contained in this application and the documents are true and correct. I understand that misrepresentation is grounds for refusal or subsequent revocation of license (Section 710-1017, Hawaii Revised Statutes.)

Date

Signature of Applicant

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

VERIFICATION OF LICENSE - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **www.state.hi.us/dcca/pvl**

State of Hawaii
Board of Medical Examiners

APPLICANT

Name (First-Middle) (LAST)	Social Security No.
Address (Include apt. no. and zip code)	LICENSE NUMBER
	DATE ISSUED

I hereby authorize the licensing agency of the state of _____ to furnish the information below to the State of Hawaii Board of Medical Examiners.

Date _____ SIGN HERE _____

LICENSING AGENCY

This is to certify that the above-named individual was issued license number _____

to practice medicine on the basis of:

[ ] NBOME Exam
[ ] Nat'l Bd & USMLE
[ ] FLEX exam - Prior to 1985
[ ] FLEX exam - After 1984
[ ] USMLE
[ ] state-constructed exam: (date passed:_____)
[ ] endorsement from: _____

Date issued: _____
Date license expires: _____

License status:
[ ] current
[ ] lapsed since: _____
[ ] inactive since: _____

Has this license ever been encumbered in any way (revoked, Suspended, surrendered, limited, placed on probation, Currently pending disciplinary action being investigated)? .....
[ ] NO
[ ] YES (Explain a yes response)

EXAMINATION SCORES

FLEX	Prior to 1985	CLINICAL COMPETENCE AVERAGE:	FLEX WEIGHTED AVERAGE:
	After 1984	COMPONENT 1	COMPONENT 2

NBOME	Part 1	Part 2	Part 3
USMLE	Step 1	Step 2	Step 3

Exam Date(s):

Exam Location(s):

Signature: _____

Title: _____

State: _____

Date: _____

BOARD SEAL

TO THE BOARD: Return this form directly to the Hawaii Board of Medical Examiners at the address below:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801

DOS-09 1001R

CERTIFICATE OF COMPETENCY - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **www.state.hi.us/dcca/pvl**

INSTRUCTIONS TO APPLICANT: Complete information ABOVE dotted line, then send a form to two (2) osteopathic physicians who will attest to your competence.

TO: *(Fill in name and address of person who will attest to your abilities);*

_____

_____

_____

RE: *(Fill in your name)* _____

(Name of Applicant)

I am applying to the Hawaii Board of Medical Examiners for a license to practice osteopathic medicine and surgery in Hawaii. It is required that I have two osteopathic physicians attest to my competency. Please complete the following form and mail it to:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96813

OR

Deliver to office location at:
1010 Richards St., 1st Floor
Honolulu, HI 96801
Phone No. (808) 586-3000

Applicant's Signature _____

.....

1. Length of Acquaintance:

   _____ yrs. _____ mos.

   Date of Last Contact:

   _____
   (month, year)

Circle Answer:

2. Is the applicant related to you? ..... YES NO

   IF YES, HOW? _____

3. What opportunities have you had to observe the applicant?

4. Do you consider the applicant: Sober and reliable? ..... YES NO
   Ethical? ..... YES NO

5. Has applicant, to your knowledge, ever been guilty of:
   a) Fraud or dishonesty? ..... YES NO
   b) Unprofessional conduct? ..... YES NO
   c) Habitual abuse of alcohol or narcotics? ..... YES NO
   d) Unprofessional advertising? ..... YES NO
   e) Practicing under an assumed name? ..... YES NO

6. To your knowledge, has there ever been any question of his mental or physical fitness to practice osteopathic medicine/surgery ..... YES NO

7. Circle one in each category:
   a) Professional ability and competency ..... EXCELLENT GOOD AVERAGE POOR
   b) Attention to duties and reliability ..... EXCELLENT GOOD AVERAGE POOR

(CONTINUED ON BACK)

8. If you have any additional information with respect to this applicant's professional ability or conduct, state here:

List all state licenses held by you:

Name of State	License No.

Completed by:

(Print or Type Name)

(Signature) (Date)

Address:

CERTIFICATE OF COMPETENCY - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **www.state.hi.us/dcca/pvl**

INSTRUCTIONS TO APPLICANT: Complete information ABOVE dotted line, then send a form to two (2) osteopathic physicians who will attest to your competence.

TO: *(Fill in name and address of person who will attest to your abilities);*

_____

_____

_____

RE: *(Fill in your name)* _____

(Name of Applicant)

I am applying to the Hawaii Board of Medical Examiners for a license to practice osteopathic medicine and surgery in Hawaii. It is required that I have two osteopathic physicians attest to my competency. Please complete the following form and mail it to:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96813

OR

Deliver to office location at:
1010 Richards St., 1st Floor
Honolulu, HI 96801
Phone No. (808) 586-3000

Applicant's Signature _____

.....

1. Length of Acquaintance:

   _____ yrs. _____ mos.

   Date of Last Contact:

   _____
   (month, year)

Circle Answer:

2. Is the applicant related to you? ..... YES NO

   IF YES, HOW? _____

3. What opportunities have you had to observe the applicant?

4. Do you consider the applicant: Sober and reliable? ..... YES NO
   Ethical? ..... YES NO

5. Has applicant, to your knowledge, ever been guilty of:
   a) Fraud or dishonesty? ..... YES NO
   b) Unprofessional conduct? ..... YES NO
   c) Habitual abuse of alcohol or narcotics? ..... YES NO
   d) Unprofessional advertising? ..... YES NO
   e) Practicing under an assumed name? ..... YES NO

6. To your knowledge, has there ever been any question of his mental or physical fitness to practice osteopathic medicine/surgery ..... YES NO

7. Circle one in each category:
   a) Professional ability and competency ..... EXCELLENT GOOD AVERAGE POOR
   b) Attention to duties and reliability ..... EXCELLENT GOOD AVERAGE POOR

(CONTINUED ON BACK)

8. If you have any additional information with respect to this applicant's professional ability or conduct, state here:

List all state licenses held by you:

Name of State	License No.

Completed by:

(Print or Type Name)

(Signature) (Date)

Address:

REQUEST FOR OSTEOPATHIC PHYSICIAN PROFILE

State of Hawaii
Board of Medical Examiners

TO THE APPLICANT: Complete the Applicant section and mail to:

American Osteopathic Association
Department of Membership and Information Services
142 East Ontario Street
Chicago, Il 60611-2864

APPLICANT

Name (First-Middle)	(LAST)	Social Security No.
Address (Include Apt. No. and zip code)		AOA Number
		Date of Birth
Osteopathic School of Graduation and Address		Date of Graduation

I am an applicant for licensure in the State of Hawaii. It is requested that you send my osteopathic physician profile directly to the Hawaii Board of Medical Examiners at the address below. I authorize the AOA to indicate on this form if there is any previous or pending disciplinary action against my license in any state.

Date _____ BY _____
(Signature of Applicant)

AOA

To AOA: Please complete and return to the Hawaii Board of Medical Examiners, P.O. Box 3469, Honolulu, Hawaii 96801.

[ ] Agrees with AOA records.

[ ] Does not agree with AOA records (include explanation).

Date _____ By _____
Member and Information Service

DOS-06 1001R

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
1010 Richards St., P.O. Box 3469
Honolulu, Hawaii 96801
www.state.hi.us/dcca/pvl

AFFIDAVIT

I, _____,

being duly sworn on oath, attest that I do not presently hold, nor have I ever held, a license issued by any state or U. S. territory.

_____
Signature

_____
Print or type name

_____
Address

_____

Indicate type of license sought:

[ ] Medical [ ] Dental [ ] Osteopathic

Subscribed and sworn to before me
this _____day of _____, 20_____

_____
Notary Public, State of _____
My commission expires: _____

LICENSING BRANCH
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

To receive confirmation of your license, fill in your name and mailing address in the block below on the "Notice of Licensure" form. This confirmation will take about 3 weeks to process. The license card will take about 6 weeks to process.

.....

NOTICE OF LICENSURE

Professional and Vocational Licensing Division
Department of Commerce and Consumer Affairs
State of Hawaii

This is authorization to act as an **OSTEOPATHIC PHYSICIAN & SURGEON** until such time that a license is processed.

THIS AUTHORIZATION IS VALID ONLY WHEN SIGNED BY THE EXECUTIVE OFFICER OF THE BOARD.

Print name and complete mailing address in block below:

LICENSE NO. DOS-

EFFECTIVE DATE

EXPIRATION DATE 6-30-

Executive Officer

DOS-08 1001R